STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING 00 B. WING	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN47240

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F0000	This visit was for the investigation of Complaint IN00092757. Complaint IN00092757 substantiated, Federal/State deficiencies related to the allegations are cited at F 323 Survey dates: July 20 and 21, 2011 Facility number: 011039 Provider number: 155675 AIM number: 200299100 Survey team: Penny Marlatt, RN Census bed type: SNF: 25 SNF/NF: 19 Residential: 24 Total: 68 Census Payor type: Medicare: 15 Medicaid: 15 Other: 38 Total: 68 Sample: 3 This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 7/25/11 Cathy Emswiller RN			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to assure a fall risk assessment was conducted upon admission and following a fall for 1 of 3 residents reviewed for falls in a sample of 3. (Resident #C) Findings include: Resident C's clinical record was reviewed on 7-21-11 at 9:50 a.m. Her diagnoses included, but were not limited to dementia, congestive heart failure (CHF), atrial fibrillation (irregular heart beat), history of urinary tract infection and urosepsis (blood infection caused by a urinary tract infection), and a history of a left hip fracture and repair in November, 2011. Resident C's admission Minimum Data Set (MDS) assessment, dated 7-12-11, indicated she was moderately cognitively impaired. It indicated she required extensive assistance of two persons for toileting, moving and positioning in bed and in transfers from one surface to	F0323	**Morning Breeze** Retirement Community & Healthcare Center 950 Lakeview Drive, Greensburg, IN 47240 Toll Free: 877-622-2228 or 812-662-7778 Fax: 812-662-7500 Dear Ms. Rhoades:Please find attached our Plan of Correction for Complaint Survey Identification number QNGR11. We believe we have met the standard for compliance with this regulation. We respectfully request a desk review of our Plan of Correction.If you have any questions, I can be reached at the facility at (812) 662-7778. Thank you so much for your time and consideration in this matter.Sincerely,Allen W. Goodman, HFAAdministratorPreparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. **F323 Free of**	08/03/2011

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	another. It indicated she required extensive assistance of one person for dressing, bathing and personal hygiene. It indicated she did not walk and used a wheelchair for mobility. It indicated she was unstable and required another person in order to stabilize herself when using the toilet, moving from a seated to a standing position and when moving from one surface to another. Review of the "Resident Admission/Readmission Assessment" form, in the section entitled, "Safety," dated 6-27-11, indicated the resident had a fall in the last 30 days, had diminished eyesight or hearing and was disoriented at times. Review of a document entitled, "Fall Risk Assessment," was blank. Review of the Nurse's Notes for 7-1-11 at 1:15 a.m., indicated Resident #C's call light was responded to at which time the resident was found lying on the floor. It indicated the resident was attempting to go to the bathroom when the fall occurred. It indicated the resident complained of right hip pain and indicated she hit the left side of her head with no visible injuries. A notation the same date at 1:45 a.m. indicated a reddened area in the midback area which measured 6 centimeters (cm) by 1 cm and three small abrasions in this area measuring less than		**Accident Hazards/Supervision/Devices** It is the intent of this facility to ensure that each resident receives Fall Risk Assessment upon admission and following a fall. **1. Action Taken:** In regards to Resident C: the Fall Risk Assessment was completed by the Director of Nursing 7/21/11 during the survey. **2. Residents Identified:** A 100% Fall Risk Assessment audit was completed for all residents 8/3/11 to ensure accuracy and the Resident Care Assignment Sheets, care plans, and assessments all were in agreement. **3. Measures Taken:** All licensed nurses were reinserviced 8/3/11 regarding the policy related to Fall Risk Assessment completion upon admission, readmission, quarterly, significant change in condition or following a fall. **4. How Monitored:** A. The Medical Records Coordinator will audit all new admission charts within 48 hours of admission or readmission for Fall Risk Assessment and report compliance to Director of Nursing and Administrator. B. MDS Coordinator/Designee will audit Fall Risk Assessments quarterly to monitor for accuracy/agreement with MDS. C. Director of Nursing/Designee will audit all accident/incident reports post-fall to ensure Fall Risk Assessment	

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	0.5 cm each. The notation indicated the resident did not complain of pain. A notation on the same date at 4:00 a.m. indicated the resident indicated she was a little sore, but okay. Review of document entitled, "Post Fall Assessment," dated 7-1-11 indicated under the heading entitled, "Gait," and "Risk," the area was blank which indicated the last fall risk score and date. Review of a document entitled, "Fall Risk Assessment," indicated the document was blank. In an interview with the Director of Nursing (DON) on 7-21-11 at 12:32 p.m., she indicated she could not find a Fall Assessment for this resident. She indicated she had completed a Fall Assessment today for this resident. In an interview with the Medical Records Designee on 7-21-11 at 2:02 p.m., indicated she normally conducts chart audits at 24 to 48 hours after an admission. She indicated she noted the Falls Assessment had not been conducted and forwarded this information on to the nurse who had conducted the admission and to the Administrator and DON in regard to Resident #C. She indicated she normally conducts a second audit at 14		has been completed with each fall event. D.Administrator/Designee will review all audits with Medical Director at quarterly Quality Assurance meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 3, 2011.**	

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	days after admission and then quarterly. She indicated she forwards her audit reports to the Administrator and the DON. She indicated she tries to follow up on any outstanding issues when she has time to do that. She indicated she does not have a specific time frame in which she follows up on any outstanding issues related to the chart audits. A policy entitled, "Fall Prevention," with an issue date of May 2008 was provided by the DON on 7-21-11 at 12:32 p.m. This policy indicated, "It is the policy of this facility to identify residents at risk for falls and to implement a fall prevention program to reduce the risk of falls and possible injury...A fall risk assessment will be completed for each resident by a licensed nurse. The assessment will be completed upon admission or readmission, quarterly, annually, and upon significant change in status." This Federal tag relates to complaint IN00092757. 3.1-45(a)(1) 3.1-45(a)(2)			